issues in the managed care debate. Protection during medical catastrophes—the confidence lent by knowing that we have a doctor, and have access to quality medical care—is one of the primary reasons we buy health insurance. We want to make sure that if someething happens to us or our family, we will be covered. It is an unjust shock to insurance-holders when their time of need comes, and they rush themselves or their loved ones to an emergency room, only to have their insurance company tell them that because they did not have the medical knowledge to foretell the true extent of the emergency, their medical care will not be covered.

It is clear why insurance companies have these policies; emergency care is the most expensive type of medical attention available. It requires 24-hour staffing and resources that must be instantaneously available for any incident. But the fact is that people buy health insurance because they know they could not afford to pay for medical care out of pocket if they needed extensive treatment. Emergency care is one of those treatments that is just too expensive to pay for up front. However, if multi-million dollar corporations cannot afford this care, surely private individuals who are also paying their monthly health insurance premiums cannot either.

Managed care companies' continuing denials of emergency care are changing the face of health care in a very broad way. What happens when insurance companies refuse to pay for treatment is that, often, it just doesn't get paid. The debate over instituting a prudent layperson standard for emergency care does not just involve patients and insurance companies, it inolves hospitals, as well. Hospitals are already required to treat uninsured patients out of their emergency rooms, and lost millions of dollars doing so. When we let insurance companies impose arbitrary limits on the type of emergency care they will cover, we essentially increase the population of uninsured that hospitals are required to serve. The number of uninsured individuals in this country is already a problem; we surely do not need to allow insurance companies to create another population of ''pseudo-insured,'' whose insurance premiums are never passed on to the health care providers.

In addition to this overarching change in the relationship between patients, hosptials and insurance companies, denials of emergency claims are also changing health care in a more personal way. Emergency rooms, aware of the unfunded liability posed by the pseudo-insured, are treting patients differently.

For example, I was contacted by one woman in Northwest Indiana, whom I shall refer to as Louise. She is not a member of a health maintenance organization (HMO). However, when she rushed her seven-year-old som to the emergency room with a broken arm, she was not able to stop home first and pick up her insurance card. The hospital, again aware that if it did not follow protocol it could be left with the bill, protected itself by acting on the assumption that she was in an HMO. The Emergency Room doctor tried to get prior authorization to run several diagnostic tests on the boy, who had fallen from a slide and was having abdominal pain in addition to the pain in his arm. He could not. But the denial did not come about becasue it was immediately obvious that there was a confusion about the insurance. Louise's participation in the HMO was not questioned. Rather authorization was denied and Louise was instead told to drive her son to a clinic thirty miles away. When the doctor attending to the boy at the emergency room objected, he was told that, because the bone was not sticking out of the skin, Louise was expected to sign a form assuming all responsibility for the boy's condition and drive him to the clinic. Instead, Louise agreed to pay for the tests out of pocket, thinking that the insurance company would surely pay for treatment if the tests proved it was necessary. She was wrong. By the time the emergency room physician reviewed the x-rays and tests and found that the boy's arm was broken at a greater than 45-degree angle, the clinic to which he had been referred had closed. When the emergency room physician again asked for permission to set the arm, Louise was told to go home and bring the boy to an orthopedic physician's office at the clinic in the morning, fourteen and one-half hours later. She was encouraged to carefully monitor her son's finger circulation and sensation, because if there was further loss of circulation or it the bone broke through the skin she would have to take him back to the emergency room. Louise could not believe the treatment her son was receiving. At this point, when her son had been lying on his back with a broked arm for five hours, the confusion over Louise's, insurance was cleared up, and her son's arm was finally treated.

Managed care organizations' unfairly limiting patients' access to emergency care is having a ripple effect on our health care system, and it has to stop. Reasonableness must be introduced into the health insurance system. It is reasonable for an insurance-holder to go to the emergency room, the emergy care must be covered. If the treatment prescribed by a licensed medical practitioner is reasonable, that must be covered as well. Letting profit-seeking obscure the basis understanding in health insurance—that you buy health insurance to pay for your health care—is wrong. The Patients' Bill of Rights, which would institute a ''prudent layperson'' standard for emergency care, will go a long way toward making it right.

Mr. FILNER. Mr. Speaker, here we go again! Once again, we hear that the Republican party wants real managed care reform, but what we see coming to us in legislation from your party is just a shell offering few real patient protections.

The bill Republicans tout as their solution to the pleas we hear from our constituents—many of whom have been the victims of harmful decisions meted out by managed care administrators—makes its mark by its failings.

Rather than protect patients, the Republican bill should be more correctly titled the ''Insurance Industry Protection Act.'' The bill leaves medical decisions in the hands of insurance company accountants and clerks, instead of doctors; fails to provide access to care from specialists; fails to provide continuity in the doctor-patient relationship; fails to provide an effective mechanism to hold plans accountable when a plan's actions or lack of action injures or kills someone; fails to respect doctors' decisions to prescribe the drugs they believe would provide the best treatment; fails to prevent plans from giving doctors financial incentives to deny care; and allows health maintenance organizations to continue to penalize patients for seeking emergency care when they belief they are in danger.

Most importantly, the Republicans' bill will not even provide its ''shell'' protection to more than 100 million of the American people—it fails to cover two-thirds of all privately insured people in the United States.

As you can see, the Republicans' bill has many failings! On the other hand, Senate Bill 6 and H.R. 358, part of the 1999 Families First (Democratic) Agenda, will deliver real protections to millions of American families. These bills, which have the backing of dozens of consumer groups, include these vital protections—and more. They provide a vital mechanism for a timely internal and independent external appeals process—an essential tool when someone's life is in the balance! But the Republicans' bill is deliberately deceiving—it was introduced in the Senate after the Democratic-sponsored bill that contains real safeguards (and is also co-sponsored by Senate Republicans,) yet those promoting this ''protection-in-name-only'' bill gave it the same name, ''The Patients' Bill of Rights.''

The Republicans and the high-powered health insurance industry are trying to scare everyday working Americans, telling them if Congress mandated the protections that the Republicans left out—and which are contained in the Democrats' bill—then health care premiums would increase. The non-partisan Congressional Budget Office, however, estimates that each person would only pay $2 a month more for the protections in the Democrats' bill.

The reality is that the cost of the Republican bill is too high.

It would continue the present system of administrators making health care decisions, exposing countless more people to inadequate care that could injure or kill them; it would force Americans to pay their own emergency room bills unless a doctor or nurse first told them to go there; and it would fail to allow doctors to freely practice medicine without the constraints of gag rules or limitations on prescription drugs.

Two dollars a month for these important patient protections is a reasonable cost for access to quality care!

Let us stop this destructive game of trying to convince people that they are better off with a reform bill that is ''reform'' in name only—that lacks the substance and real protections! To offer so-called ''protections'' with few safeguards to back them up is a deadly game we should not be playing!

GENERAL LEAVE

Ms. WOOLSEY. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on the subject of my special order.

The SPEAKER pro tempore. Is there objection to the request of the gentlewoman from California?

There was no objection.